PPQCMS

Primary Prevention *Quality* Care Monitoring System

MT ND WY

WHAT IS THE PPQCMS SYSTEM?

The Primary Prevention Quality Care Monitoring System (PPQCMS) is a simple electronic tool to track and manage individuals with multiple cardiovascular risk factors, metabolic syndrome and/or pre-diabetes. The PPQCMS allows office-based practices to incorporate referrals to local community programs. It is designed to be the "sister" program to the Diabetes Quality Care Management System (DQCMS); a simple tracking software widely used in Montana.

Individual patient profiles can be generated to display progress and reinforce treatment and lifestyle goals.

The software is available free of charge

PPQCMS Goal:

To provide an **office based** tool to assist busy clinicians in assessing practice patterns for reducing risk for multiple cardiovascular and diabetes risk factors.

PPQCMS uses the same principles as DQCMS

Simple

Action-oriented

Easy to maintain

No direct cost to offices working with MT DPHHS

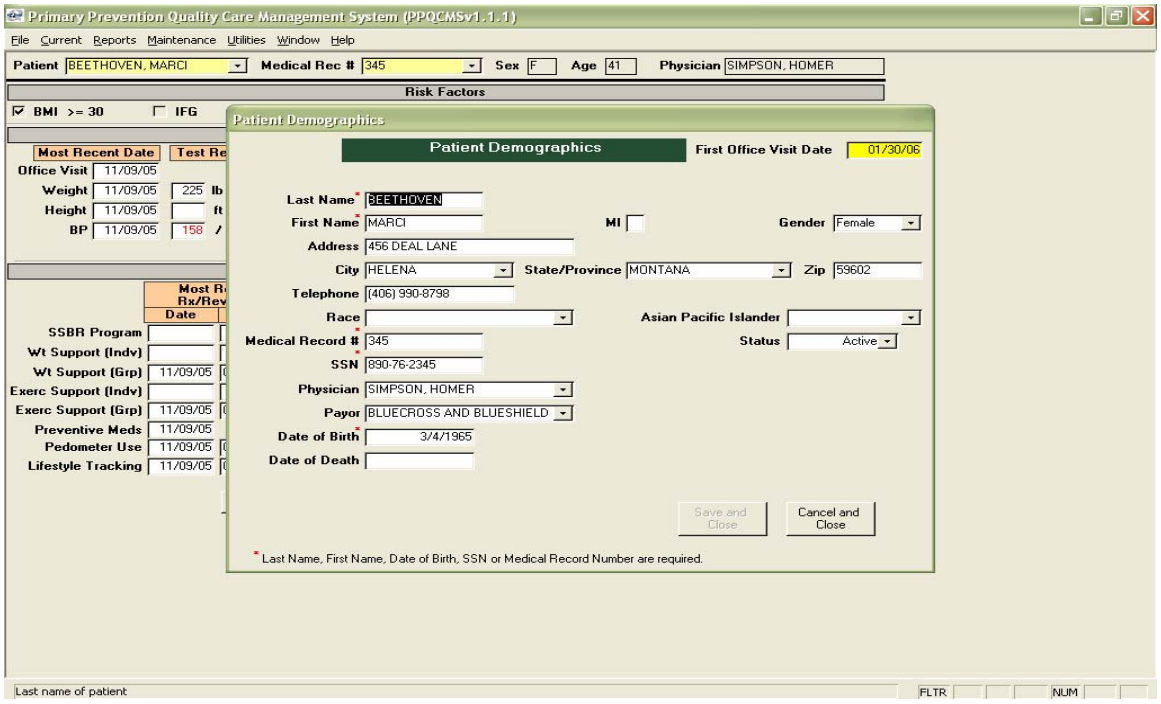
Pre-programmed reports to evaluate your outcomes

Adaptable to practice in your community

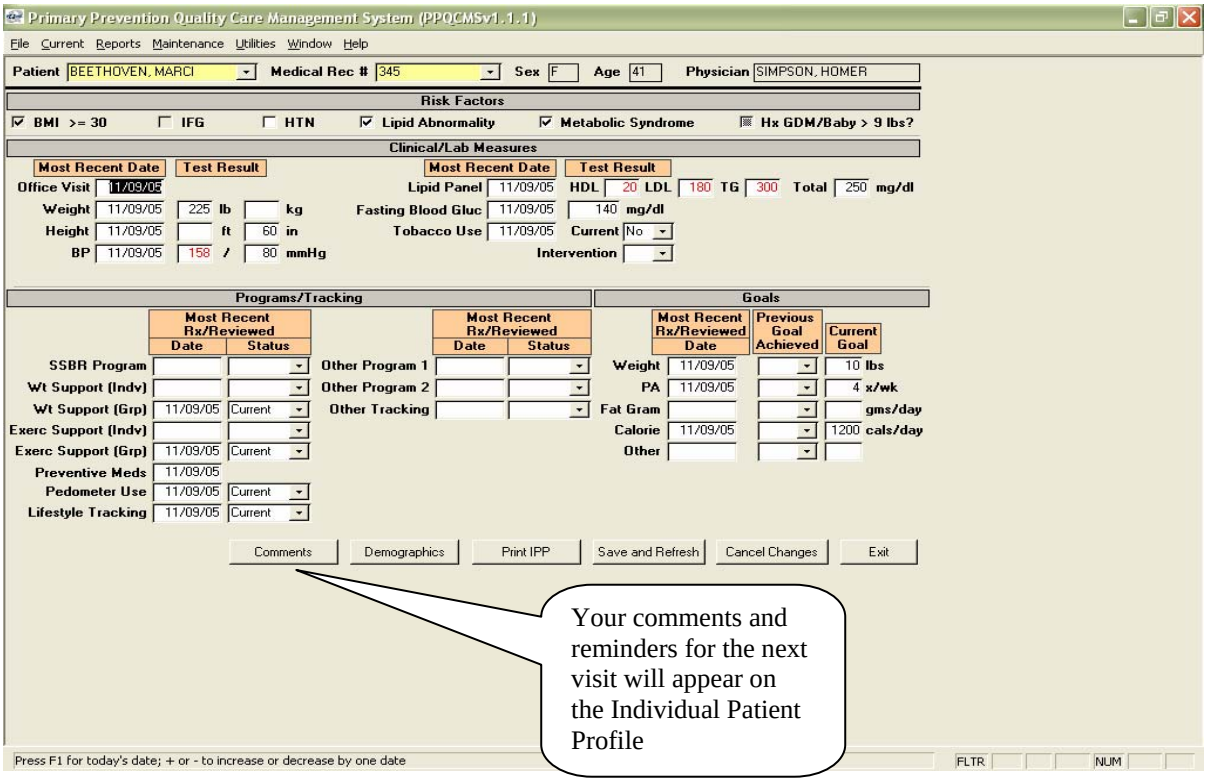
More can be accomplished by working together!

Supporting continuous, high quality preventive care!

A Simple Demographic Screen



A Single Data Entry Screen for Clinical Parameters



You define programs/referrals available in your community – Health Clubs, Community programs

Patient Practice Profile reflects practice patterns and progress in this population

Date Generated: 08/17/06

Population Practice Profile*

PPQCMSv1.1.1

LIZ CLINIC

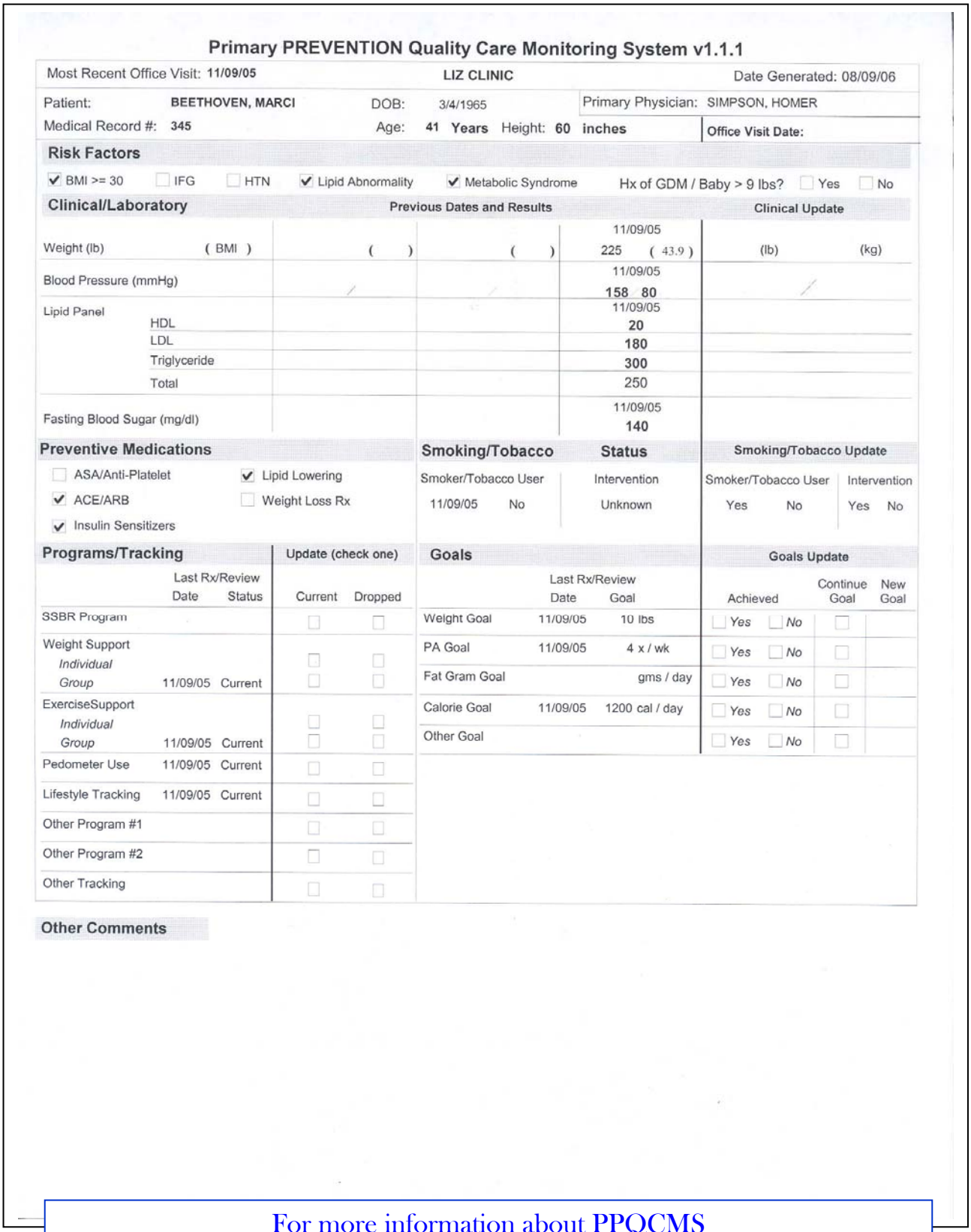
Number of patients with office visits in the last year: **4**

Total active patient population: **4**

	OV Past Year		All Patients	
Risk Profile	%	#	%	#
Patients with BMI ≥ 30	100.0	(4/4)	100.0	(4/4)
Patients with abnormal lipids	100.0	(4/4)	100.0	(4/4)
Patients with IFG	0.0	(0/4)	0.0	(0/4)
Patients with metabolic syndrome	75.0	(3/4)	75.0	(3/4)
Women with adverse obstetrical history	50.0	(1/2)	150.0	(1/2)
Prevention Processes				
Of patients with >= 2 office visit(s) in the last year, the percent currently in SSBR	0.0	(0/0)	0.0	(0/0)
Of patients with >= 2 office visit(s) in the last year, the percent currently in Lifestyle Tracking	0.0	(0/0)	0.0	(0/0)
Patients on Insulin Sensitizers	50.0	(2/4)	50.0	(2/4)
Of patients currently smoking / using tobacco, the percent receiving cessation intervention in the last year.	100.0	(2/2)	100.0	(2/2)
Of patients currently smoking/using tobacco, the percent currently participating in/using	0.0	(0/2)	0.0	(0/2)
Individual Outcomes				
Body Weight				
Of patients with >= 2 office visit(s) in the last year, the percent losing >= 5 % of body weight since baseline	0.0	(0/0)	0.0	(0/0)
Glucose Tolerance				
Patients with FBS test in the last year	100.0	(4/4)	100.0	(4/4)
Of patients with FBS test in the last year, the percent whose most recent FBS < 100	0.0	(0/4)	0.0	(0/4)
Of patients with FBS test in the last year, the percent whose most recent FBS > 126	100.0	(4/4)	100.0	(4/4)
Lipid Abnormality				
Patients with a lipid profile in the last year	100.0	(4/4)	100.0	(4/4)
Of patients with HDL in the last year, the percent whose most recent HDL > 40	0.0	(0/4)	0.0	(0/4)
Of patients with Triglyceride in the last year, the percent whose most recent Triglyceride < 150	0.0	(0/4)	0.0	(0/4)
Of patients with LDL in the last year, the percent whose most recent LDL < 130	0.0	(0/4)	0.0	(0/4)
Hypertension				
Of patients with >= 1 office visit(s) in the last year, the percent whose most recent syst < 130 and dias < 85	0.0	(0/4)	0.0	(0/4)
Program Outcome				
Of patients currently in SSBR, the percent who have lost >= 5% of body weight since baseline	0.0	(0/0)	0.0	(0/0)
Patients who have achieved >= 2 goals in the last 12 months	0.0	(0/4)	0.0	(0/4)

* Includes only patients >= 18 years of age.

Individual Patient Profile reflects clinical progress and is used to update record



Primary PREVENTION Quality Care Monitoring System v1.1.1

Most Recent Office Visit: **11/09/05** — **LIZ CLINIC** — Date Generated: 08/09/06

Patient: **BEETHOVEN, MARCI** DOB: 3/4/1965 Primary Physician: SIMPSON, HOMER

Medical Record #: **345** Age: **41 Years** Height: **60 inches** Office Visit Date:

Risk Factors

☑ BMI >= 30 ☐ IFG ☐ HTN ☑ Lipid Abnormality ☑ Metabolic Syndrome Hx of GDM / Baby > 9 lbs? ☐ Yes ☐ No

Clinical/Laboratory

	Previous Dates and Results			Clinical Update
			11/09/05	
Weight (lb) (BMI)	( )	( )	225 (43.9)	(lb) (kg)
Blood Pressure (mmHg)			11/09/05 158 80	
Lipid Panel			11/09/05	
HDL			20	
LDL			180	
Triglyceride			300	
Total			250	
Fasting Blood Sugar (mg/dl)			11/09/05 140	

Preventive Medications

☐ ASA/Anti-Platelet ☑ Lipid Lowering
☑ ACE/ARB ☐ Weight Loss Rx
☑ Insulin Sensitizers

Smoking/Tobacco

Smoking/Tobacco	Status	Smoking/Tobacco Update	
Smoker/Tobacco User	Intervention	Smoker/Tobacco User	Intervention
11/09/05 No	Unknown	Yes No	Yes No

Programs/Tracking

	Last Rx/Review Date	Status	Update (check one) Current	Dropped
SSBR Program			☐	☐
Weight Support				
Individual			☐	☐
Group	11/09/05	Current	☐	☐
ExerciseSupport				
Individual			☐	☐
Group	11/09/05	Current	☐	☐
Pedometer Use	11/09/05	Current	☐	☐
Lifestyle Tracking	11/09/05	Current	☐	☐
Other Program #1			☐	☐
Other Program #2			☐	☐
Other Tracking			☐	☐

Goals

	Last Rx/Review Date	Goal	Goals Update Achieved	Continue Goal	New Goal
Weight Goal	11/09/05	10 lbs	☐ Yes ☐ No	☐	
PA Goal	11/09/05	4 x / wk	☐ Yes ☐ No	☐	
Fat Gram Goal		gms / day	☐ Yes ☐ No	☐	
Calorie Goal	11/09/05	1200 cal / day	☐ Yes ☐ No	☐	
Other Goal			☐ Yes ☐ No	☐	

Other Comments

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or the Montana Diabetes Project Contact:

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